Palomar Health

Medicare Community-Based Care Transitions Program (CCTP)

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Service Area

- 3 Acute Care Hospitals
- 1 Skilled Nursing Facility
- Home Health Agency
- 3 Ambulatory Care Centers
- 4 Retail Health Clinics

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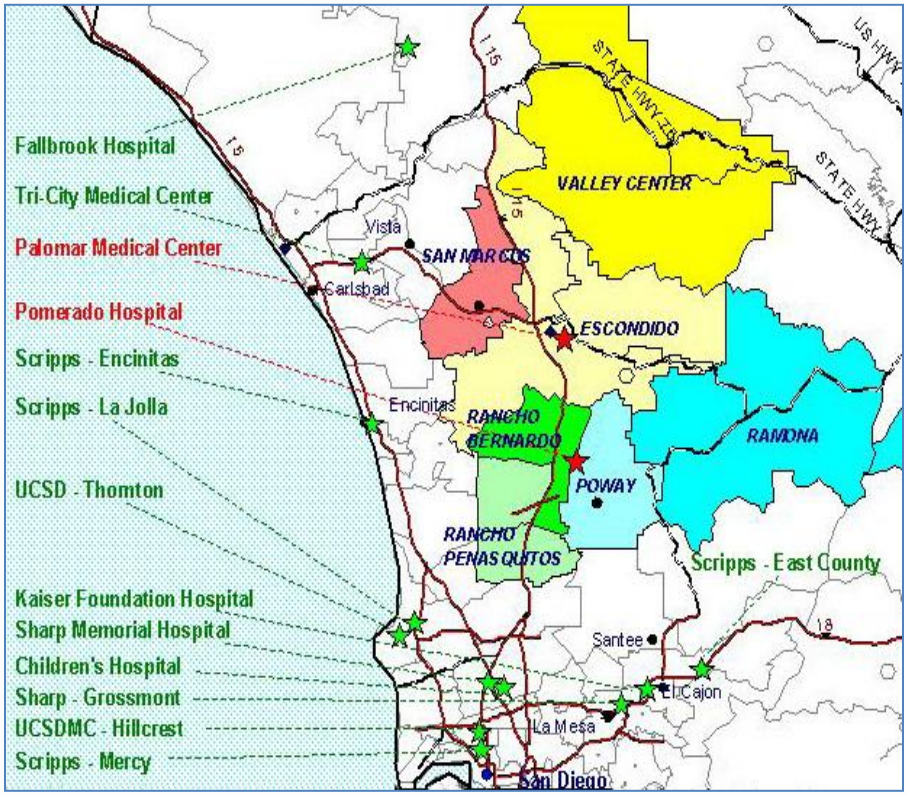
Palomar Health by the Numbers

- 4500 Employees
- 840 Physicians
- 760 Volunteers
- 850 Clinical Career Extenders
- $2.4 Billion Gross Revenue
- 244,100 Weighted Patient Days
- 101,200 Emergency Visits
- 55,000 Home Health Visits
- 850 Square Mile Health District
- 2200 Square Mile Trauma District



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Goals of CCTP

- Improve transitions of beneficiaries from the inpatient hospital setting to other care settings
- Improve quality of care
- Reduce readmissions for high risk beneficiaries
- Document measureable savings to the Medicare Program

(readmissions cost approx $14,000-$15,000)

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The Palomar Approach

- Our target population anticipated 2879 High Risk Patients out of 6758 (Medicare Discharges from 2010 CMS data)
- Direct Service will be provided by High Risk Healthcare Coaches (HRHC) (2879 patients)
- Direct Service by a Pharmacist (1200 patients)

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Initial High Risk Criteria based on RCA at Palomar Health

- Eight or more medications
- Multiple Chronic Conditions
- AMI or PNEU or CHF
- Two or more readmissions in the past twelve months
- Two or more ED visits in the past 6 months

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PDSA

- Identified the need to streamline CTI referral process
- Identified that more patients were being discharged to extended care facilities

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Rule Out Criteria:

- Chemo in past 6 months
- Terminal cancers, stage IV, or active treatment
- ESRD with >2 ED visits in the last 6 months
- Uncontrolled psychiatric illnesses without a caregiver
- Pt's with expressive or receptive aphasia WITHOUT a caregiver
- Enrolled in CCTP or CTI in the last 6 months

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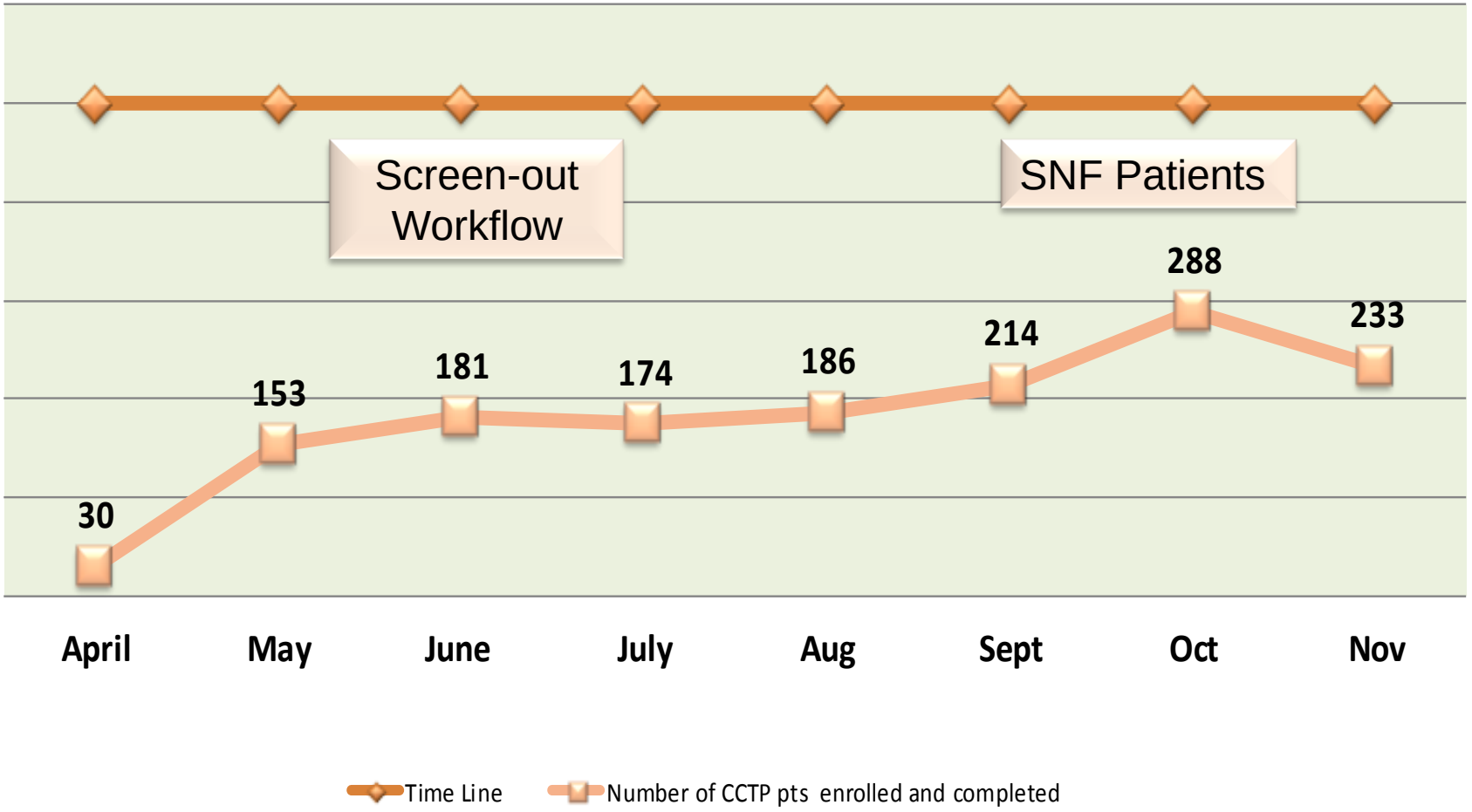
Timeline and Enrollment Volume



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Interventions by High Risk Coaches

- Receive referrals identified at admission
- Round with hospitalists to facilitate communication with PCP
- Daily visits with pt/family to determine barriers to learning & best teaching methods
- Confer with CNS, pharmacist & other pt educators
- Verbal handoff to CTI (County follow-up)
- Phone Call F/U (5-7 days after Discharge)

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Interventions by Pharmacist

- Assess barriers in pt compliance to drug therapy
- Provide patient ed. on home medication
- Resolve pharmacy-specific barriers for safe discharge
  - Utilize low-cost generic plans when available
  - Work with insurance to arrange auth if required
  - Pharm Assistance Program (financial assistance)

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REPORT ELEMENT (for the reporting month)	July				August				September				October			
	PMC	POM	Both	Rate	PMC	POM	Both	Rate	PMC	POM	Both	Rate	PMC	POM	Both	Rate
Total Medicare FFS Admissions	335	152	487		357	126	483		367	125	492		372	177	549	
Medicare FFS Admissions meeting initial eligibility criteria[1] for CCTP core services (IP, exclude MHU, ARU, LDR- A & B only)	302	151	453		329	119	448		337	120	457		322	160	482	
Number of patients approached to participate in CCTP core services	108	86	194		130	71	201		162	55	217		224	69	293	
Number of CCTP completed patients readmitted within 30 days.	8	4	12	**7%**	4	1	5	**2.69%**	9	7	16	**7.37%**	15	7	22	**7.64%**
Medicare FFS Readmissions meeting initial eligibility criteria for CCTP core services (IP, exclude MHU, ARU, LDR- A & B only)	42	18	60	**13.25%**	39	16	55	**12.28%**	42	17	59	**12.91%**	41	14	55	**11.41%**
High-Risk Healthcare Coach	**100**	**74**	**174**	**38.41%**	**124**	**62**	**186**	**41.52%**	**162**	**52**	**214**	**46.83%**	**222**	**66**	**288**	**46.06%**
Pharmacist	**9**	**20**	**29**	**17%**	**53**	**53**	**106**	**56.99%**	**93**	**33**	**126**	**58.88%**	**193**	**60**	**253**	**87.85%**
Referred to AIS CTI	**27**	**22**	**49**	**28.16%**	**56**	**31**	**87**	**47%**	**115**	**48**	**163**	**76%**	**144**	**64**	**208**	**72%**

Monthly Metrics

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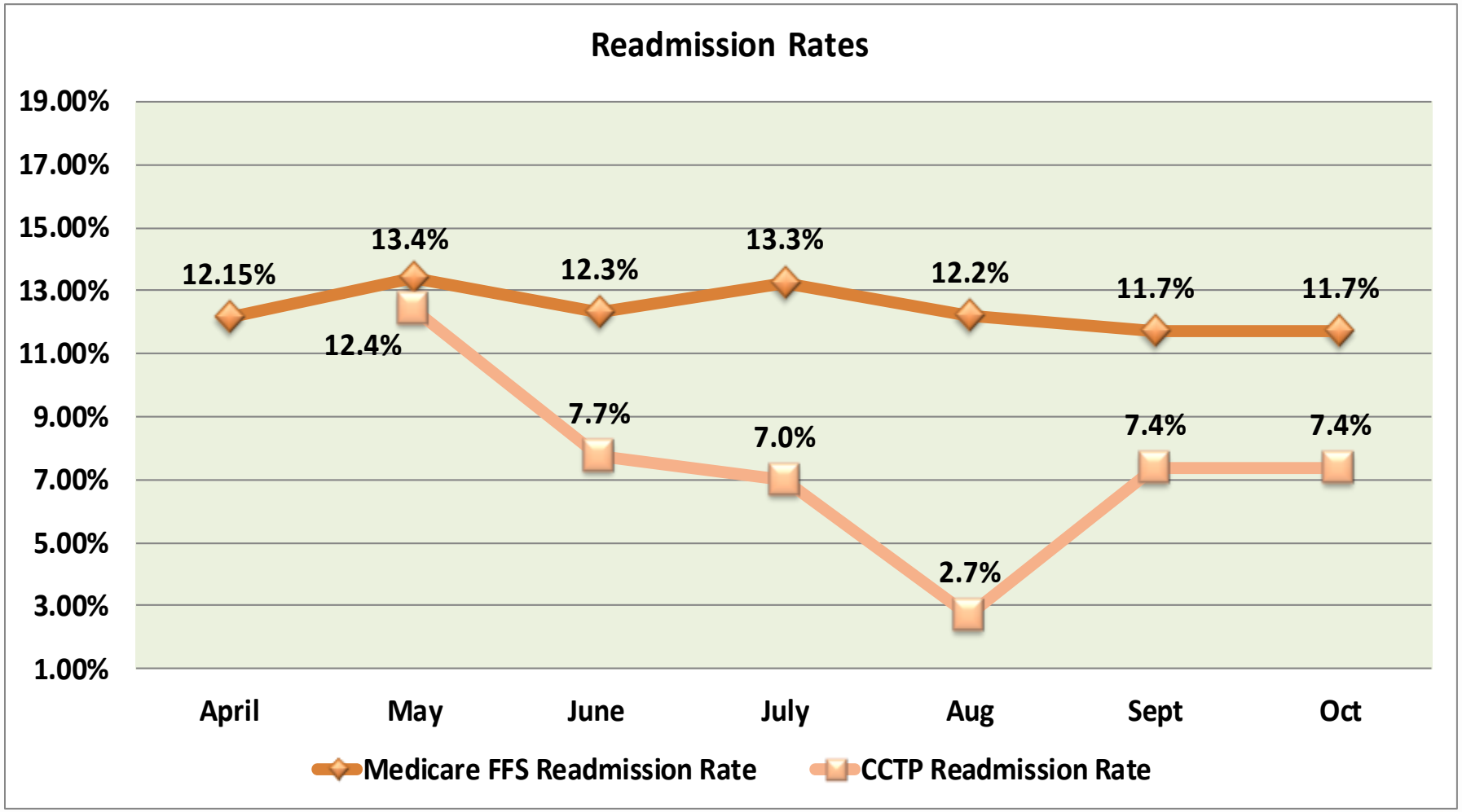

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Lessons Learned

- Increase footprint
- Importance of Partnerships
  - Regional workgroup -Pharmacy
  - SNF relationships -Internal Departments
  - PCP relationships -Home Health
- Importance of Case Reviews and need for Care Coordination
- “You build it, they will come!!”

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